

NOTICE TO INSUREDS

READ THIS NOTE CAREFULLY BEFORE ACCESSING THE
FOLLOWING INFORMATION.

Metlife is providing this Electronic Document describing the insurance benefits provided for in your certificate of insurance as a convenience at the request of Rensselaer Polytechnic Institute. Rensselaer Polytechnic Institute. maintains the group insurance policy, including a copy of the certificate of insurance that is available for you to review and copy if necessary. If there is any conflict between the information in this Electronic Document and the group insurance policy and certificate, the policy and certificate shall control in all respects.

**YOUR EMPLOYEE
BENEFIT PLAN**

RENSSELAER POLYTECHNIC INSTITUTE

Dental Benefits

Rensselaer Polytechnic Institute
2144 Burdett Avenue
Troy, NY 12180

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

Benefits are provided through a group policy issued to Rensselaer Polytechnic Institute by Metropolitan Life Insurance Company.

Rensselaer Polytechnic Institute



Metropolitan Life Insurance Company
One Madison Avenue, New York, New York 10010-3690

Certifies that, under and subject to the terms and conditions of the Group Policy issued to the Employer, coverage is provided for each Employee as defined herein.

The date when an Employee is eligible for coverage is set forth in the form with the title Eligibility for Benefits.

The date when an Employee's Personal Benefits become effective is set forth in the form with the title Effective Dates of Personal Benefits.

The date when an Employee's Dependent Benefits become effective is set forth in the form with the title Effective Dates of Dependent Benefits.

The amounts of coverage are determined by the form with the title Schedule of Benefits.

A handwritten signature in black ink, appearing to read "Robert H. Benmosche".

Robert H. Benmosche
Chairman, President and Chief Executive Officer

Employer: **Rensselaer Polytechnic Institute**

Group Policy No.: **1127444-G**

Florida Residents: The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.

For Maryland residents: The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

If any prior certificate relating to the coverage set forth herein has been given to the Employee, such certificate is void.

Form G.23000-Cert.-1

For Texas Residents:

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call MetLife's toll-free telephone number for information or to make a complaint at

1-800-638-5433

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact MetLife first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR CERTIFICATE: This notice is for information only and does not become a part or condition of the attached document.

Para Residentes de Texas:

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de MetLife para informacion o para someter una queja al

1-800-638-5433

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con MetLife primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU CERTIFICADO: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

Arkansas residents please be advised of the following:

IMPORTANT NOTICE

IF YOU HAVE A QUESTION CONCERNING YOUR COVERAGE OR A CLAIM, FIRST CONTACT YOUR GROUP EMPLOYER OR GROUP ACCOUNT ADMINISTRATOR. IF, AFTER DOING SO, YOU STILL HAVE A CONCERN, YOU MAY CALL METLIFE'S TOLL-FREE TELEPHONE NUMBER:

1-800-638-5433

IF YOU ARE STILL CONCERNED AFTER CONTACTING BOTH YOUR GROUP EMPLOYER AND METLIFE, YOU SHOULD FEEL FREE TO CONTACT:

**ARKANSAS INSURANCE DEPARTMENT
CONSUMER SERVICES DIVISION
1200 WEST THIRD
LITTLE ROCK, ARKANSAS 72201-1904**

California residents please be advised of the following:

IMPORTANT NOTICE

**TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT,
CONTACT METLIFE AT:**

**METROPOLITAN LIFE INSURANCE COMPANY
1 MADISON AVENUE
NEW YORK, NY 10010
ATTN: CORPORATE CONSUMER RELATIONS DEPARTMENT
1-800-638-5433**

**IF, AFTER CONTACTING METLIFE REGARDING A COMPLAINT, YOU FEEL
THAT A SATISFACTORY RESOLUTION HAS NOT BEEN REACHED, YOU MAY
FILE A COMPLAINT WITH THE CALIFORNIA INSURANCE DEPARTMENT AT:**

**CALIFORNIA DEPARTMENT OF INSURANCE
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013
1-800-927-4357 (within California)
1-213-897-8921 (outside California)**

Georgia residents please be advised of the following:

IMPORTANT NOTICE

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

Utah residents please be advised of the following:

NOTICE TO POLICYHOLDERS

Insurance companies licensed to sell life insurance, health insurance, or annuities in the State of Utah are required by law to be members of an organization called the Utah Life and Health Insurance Guaranty Association ("ULHIGA"). If an insurance company that is licensed to sell insurance in Utah becomes insolvent (bankrupt), and is unable to pay claims to its policyholders, the law requires ULHIGA to pay some of the insurance company's claims. The purpose of this notice is to briefly describe some of the benefits and limitations provided to Utah insureds by ULHIGA.

PEOPLE ENTITLED TO COVERAGE

- You must be a Utah resident.
- You must have insurance coverage under an individual or group policy.

POLICIES COVERED

- ULHIGA provides coverage for certain life, health and annuity insurance policies.

EXCLUSIONS AND LIMITATIONS

Several kinds of insurance policies are specifically excluded from coverage. There are also a number of limitations to coverage. The following are not covered by ULHIGA:

- Coverage through an HMO.
- Coverage by insurance companies not licensed in Utah.
- Self-funded and self-insured coverage provided by an employer that is only administered by an insurance company.
- Policies protected by another state's Guaranty Association.
- Policies where the insurance company does not guarantee the benefits.
- Policies where the policyholder bears the risk under the policy.
- Re-insurance contracts.
- Annuity policies that are not issued to and owned by an individual, unless the annuity policy is issued to a pension benefit plan that is covered.
- Policies issued to pension benefit plans protected by the Federal Pension Benefit Guaranty Corporation.
- Policies issued to entities that are not members of the ULHIGA, including health plans, fraternal benefit societies, state pooling plans and mutual assessment companies.

LIMITS ON AMOUNT OF COVERAGE

Caps are placed on the amount ULHIGA will pay. These caps apply even if you are insured by more than one policy issued by the insolvent company. The maximum ULHIGA will pay is the amount of your coverage or \$500,000 — whichever is lower. Other caps also apply:

- \$100,000 in net cash surrender values.
- \$500,000 in life insurance death benefits (including cash surrender values).
- \$500,000 in health insurance benefits.
- \$200,000 in annuity benefits — if the annuity is issued to and owned by an individual or the annuity is issued to a pension plan covering government employees.
- \$5,000,000 in annuity benefits to the contract holder of annuities issued to pension plans covered by the law. (Other limitations apply).
- Interest rates on some policies may be adjusted downward.

DISCLAIMER

PLEASE READ CAREFULLY:

· **COVERAGE FROM ULHIGA MAY BE UNAVAILABLE UNDER THIS POLICY. OR, IF AVAILABLE, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS. THE DESCRIPTION OF COVERAGES CONTAINED IN THIS DOCUMENT IS AN OVERVIEW. IT IS NOT A COMPLETE DESCRIPTION. YOU CANNOT RELY ON THIS DOCUMENT AS A DESCRIPTION OF COVERAGE. FOR A COMPLETE DESCRIPTION OF COVERAGE, CONSULT THE UTAH CODE, TITLE 31A, CHAPTER 28.**

· **COVERAGE IS CONDITIONED ON CONTINUED RESIDENCY IN THE STATE OF UTAH.**

· **THE PROTECTION THAT MAY BE PROVIDED BY ULHIGA IS NOT A SUBSTITUTE FOR CONSUMERS' CARE IN SELECTING AN INSURANCE COMPANY THAT IS WELL-MANAGED AND FINANCIALLY STABLE.**

· **INSURANCE COMPANIES AND INSURANCE AGENTS ARE REQUIRED BY LAW TO GIVE YOU THIS NOTICE. THE LAW DOES, HOWEVER, PROHIBIT THEM FROM USING THE EXISTENCE OF ULHIGA AS AN INDUCEMENT TO SELL YOU INSURANCE.**

· **THE ADDRESS OF ULHIGA, AND THE INSURANCE DEPARTMENT ARE PROVIDED BELOW.**

Utah Life and Health Insurance
Guaranty Association
955 E. Pioneer Rd.
Draper, Utah 84114

Utah Insurance Department
State Office Building, Room 3110
Salt Lake City, Utah 84114

Virginia residents please be advised of the following:

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number:

Metropolitan Life Insurance Company
1 Madison Avenue
New York, New York 10010
Attn: Corporate Customer Relations Department

To phone in a claim related question, you may call Claims Customer Service at:

1-800-638-5433

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23209

1-800-552-7945 - In-state toll-free

1-804-371-9691 - Out-of-state

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Wisconsin residents please be advised of the following:

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

Metropolitan Life Insurance Company
Corporate Consumer Relations Department
1 Madison Avenue
New York, NY 10010
1-800-638-5433

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517 outside of Madison or 266-0103 in Madison.

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Metropolitan Life Insurance Company
One Madison Avenue, New York, New York 10010-3690

Endorsement

This certificate is hereby endorsed as follows:

With respect to Employees who are Texas residents, for Dental Expense Benefits, the term "dependent" includes the Employee's unmarried grandchild who is under age 25, living in the Employee's household and a dependent of the employee for federal income tax purposes at the time the grandchild is enrolled for coverage.

A handwritten signature in black ink, appearing to read "Robert H. Benmosche". The signature is stylized and cursive.

Robert H. Benmosche
Chairman, President and Chief Executive Officer

G.23000-LEG-TXDEP

SCHEDULE OF BENEFITS
(Also see SCHEDULE SUPPLEMENT)

The following Benefits are provided subject to the provisions below.

BENEFITS (EMPLOYEE AND DEPENDENT) **AMOUNT**

DENTAL EXPENSE BENEFITS

	<u>In-Network</u>	<u>Out-of-Network</u>
ANNUAL DEDUCTIBLE AMOUNT (For Type B and Type C Expenses Combined)		
Individual	\$50	\$50
Family.....	\$100	\$100
COVERED PERCENTAGE		
Type A Expenses	100%	100%
Type B Expenses	80%	80%
Type C Expenses	50%	50%
Type D Expenses.....	50%	50%
MAXIMUMS		
For Orthodontic Treatment Aggregate Maximum Benefit (For All Dental Expense Periods).....		\$1,500
For Other Covered Dental Expenses Maximum Benefit (For One Dental Expense Period).....		\$1,500

NOTE(S)

Covered Dental Expenses for orthodontia are not included in the Maximum Benefit For One Dental Expense Period.

If a dental bill is expected to be \$300 or more, see DENTAL EXPENSE BENEFITS, section F. PRE-DETERMINATION OF BENEFITS.

COORDINATION OF BENEFITS

The Dental Expense Benefits are subject to the provisions of the form entitled COORDINATION OF BENEFITS.

WHEN YOU RETIRE

No benefits are provided under This Plan on or after the day you retire.

Form G.23000-B

SCHEDULE SUPPLEMENT

A. Statements Made by You Which Relate to Insurability

Any statement made by you will be deemed a representation and not a warranty.

No such statement made by you which relates to insurability will be used:

1. in contesting the validity of the benefits with respect to which such statement was made; or
2. to reduce the benefits;

unless the conditions listed in items (a) and (b) below have been met:

- a. The statement must be contained in a written application which has been signed by you.
- b. A copy of the application has been furnished to you.

No such statement made by you will be used at all after such benefits have been in force prior to the contest for a period of two years during the lifetime of the person to whom the statement applies.

B. Assignment

This certificate may not be assigned by you. Your benefits may not be assigned prior to a loss.

For Texas Residents: Upon receipt of services for a Covered Dental Expense, you may assign Dental Expense Benefits to the Dentist providing such care.

C. Refund to Us for Overpayment of Benefits

If we pay Dental Expense Benefits to you for expenses incurred on your own account or on account of a Dependent, and it is found that we paid more Dental Expense Benefits to you than we should have paid because:

1. all or some of those expenses were not paid for by the Covered Persons in your Family; or
2. any Covered Person in your Family was repaid for all or some of those expenses by a source other than from:
 - a. an insurer under a policy of insurance issued to you in your name; and
 - b. an insurer under a policy of insurance issued to a Covered Person in your Family who ordinarily lives in your home; and
 - c. us;

we will have the right to a refund from you. The amount of the refund is the difference between:

1. the amount of Dental Expense Benefits paid by us for those expenses; and
2. the amount of Dental Expense Benefits which should have been paid by us for those expenses.

However, at our option, we may recover the excess amount by reducing or offsetting any future benefits payable to such person by the amount of the overpayment.

D. Additional Provisions

1. The benefits under This Plan do not at any time provide paid-up insurance, or loan or cash values.
2. No agent has the authority:
 - a. to accept or to waive the required proof of a claim; nor
 - b. to extend the time within which a proof must be given to us.

Form G.23000-B1

DEFINITIONS OF CERTAIN TERMS USED HEREIN

"Actively at Work" or "Active Work" means that you are performing all of the material duties of your job with the Employer where these duties are normally carried out. If you were Actively at Work on your last scheduled working day, you will be deemed Actively at Work:

1. on a scheduled non-working day;
2. provided you are not disabled.

"Covered Person" means an Employee or a Dependent on whose account benefits are in effect under This Plan.

"Dependent" means your spouse or your unmarried natural child except for:

1. a person who is in the military or like forces of any country or of any subdivision of a country;
2. a person who is eligible under This Plan as an Employee;
3. a person who lives outside the United States or Canada;
4. a child who:
 - a. is 19 years of age or older and who is employed on a full-time basis; or
 - b. is 19 years of age or older and who is not a full-time student at an approved school, as determined by the Employer; or
 - c. is 25 years of age or older.

If a Dependent child is a Covered Person on the day before that child has reached the applicable age limit, that child will continue to be a Dependent after the age limit as long as:

- a. that child is and remains unable to work in self-sustaining employment because of:
 - i. physical handicap; or
 - ii. mental illness, developmental disability, or mental retardation, as defined in the Mental Hygiene Law of New York State; and
- b. that child is and remains chiefly dependent upon you for support; and
- c. that child is and remains a Dependent, as defined, except for the age limit; and
- d. you give us proof, when we ask for it, that the child is and remains so unable to work and dependent upon you since the age limit. We will not ask for proof more than once a year. The proof must be satisfactory to us; and
- e. you make any payment which is required by the Employer.

Subject to the same conditions which apply to a natural child, child also includes:

- a. a child who is supported solely by you and permanently living in the home of which you are the head; and
- b. a child who is legally adopted; and
- c. a stepchild who lives in your home provided the natural parent's signature, approving such coverage, is included on the enrollment form.

No person may be covered as a Dependent of more than one Employee.

"Dependent Benefits" mean the benefits which are provided on account of a Dependent under This Plan.

"Doctor" means a person who is legally licensed to practice medicine. A licensed practitioner will be considered a Doctor if:

1. there is a law which applies to This Plan and that law requires that any service performed by such a practitioner must be considered for benefits on the same basis as if the service were performed by a Doctor; and
2. the service performed by the practitioner is within the scope of his or her license.

"Employee" means a person who is employed and paid for services by the Employer on a full-time regular or fixed term or a part time regular or fixed term basis and scheduled to work 1,440 hour per year.

"Family" means you and your Dependents.

"No Fault Law" means a motor vehicle liability law or other similar law which requires that benefits be provided for personal injury without regard to fault.

"Occupational Injury" means an injury which happens in the course of any work performed by the Covered Person for wage or profit.

"Occupational Sickness" means a sickness which entitles the Covered Person to benefits under a worker's compensation or occupational disease law.

"Personal Benefits" mean the benefits which are provided on account of an Employee under This Plan.

"Qualifying Events" means a change in your family, employment or group coverage status which would affect your Benefits under This Plan due to one or more of the following:

1. marriage;
2. birth, adoption or placement for adoption of a dependent child;
3. divorce, legal separation or annulment;
4. death of a dependent;
5. your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage;
6. a change in your or your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes you or your dependent to gain or lose eligibility for group coverage;
7. you previously did not enroll for dental coverage for you or your dependent because you had other group coverage, but that coverage has ceased due to one or more of the following reasons:
 - a. loss of eligibility for the other group coverage; or
 - b. COBRA continuation of the other group coverage was exhausted;
8. a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires either:
 - a. you to provide health coverage for your child or dependent foster child; or
 - b. your spouse, former spouse or other individual to provide coverage for your child or foster child if that other person does in fact provide that coverage;
9. you or your dependent lose entitlement to Medicare or Medicaid eligibility.

"This Plan" means the Group Policy which is issued by us to provide Personal Benefits and Dependent Benefits.

"We", **"us"** and **"our"** mean Metropolitan.

"You" and **"your"** mean the Employee who is a Covered Person for Personal Benefits. They do not include a Dependent of the Employee.

Form G.23000-A

ELIGIBILITY FOR BENEFITS

Personal Benefits Eligibility Date

If you are an Employee on January 1, 2005, that is your Personal Benefits Eligibility Date.

If you become an Employee after January 1, 2005, your Personal Benefits Eligibility Date is the first day of the month after the date you become an Employee of the Employer.

Dependent Benefits Eligibility Date

Your Dependent Benefits Eligibility Date is the later of your Personal Benefits Eligibility Date and the date you first acquire a Dependent.

Form G.23000-C

EFFECTIVE DATES OF PERSONAL BENEFITS

A. Making a Request for Benefits

1. Your Employer has established a flexible benefits plan. Under such a plan, you can choose the amount and types of benefits subject to the rules of the plan. Such rules include time frames during which you may make a request to be covered or to change your benefits under This Plan as set forth below. Such rules also establish a time frame for when changes in the amount of your benefits are made as a result of a change in your class or earnings. Your Employer can provide you with more information regarding the flexible benefits plan. In order to become covered for Personal Benefits under This Plan, you must make a written request to the Employer on the flexible benefits enrollment form furnished by the Employer.

In general, you can make choices for coverage for Personal Benefits:

- a. when you are first eligible for Personal Benefits; and
- b. when you have a Qualifying Event and want to make a change in your coverage for Personal Benefits to be more consistent with your new family status; and
- c. during the annual enrollment period as designated by the Employer and reported to you.

Requests to be covered for Personal Benefits may only be made:

- a. during the first and any subsequent annual enrollment period, as designated by the Employer and reported to you, following your Personal Benefits Eligibility Date; or
- b. during the thirty-one day period following your Personal Benefits Eligibility Date; or
- c. within thirty-one days of a Qualifying Event.

If you are already covered for Personal Benefits, requests for changes in Personal Benefits may only be made:

- a. during the annual enrollment period, as designated by the Employer and reported to you; or
- b. within thirty-one days of a Qualifying Event, provided that the change in coverage is consistent with your new family status.

2. If you make a request to be covered for Personal Benefits within thirty-one days of your Personal Benefits Eligibility Date, your Personal Benefits will become effective on your Personal Benefits Eligibility Date, subject to the Active Work Requirement.

3. If you make a request to be covered for Personal Benefits or a request for change(s) in Personal Benefits within thirty-one days of a Qualifying Event, your Personal Benefits or the change(s) in Personal Benefits will become effective on the first day of the month following the date of your request, subject to the Active Work Requirement, and provided that the change in coverage is consistent with your new family status.
4. If you make a request to be covered for Personal Benefits during an annual enrollment period, but after your Personal Benefits Eligibility Date, your Personal Benefits will become effective one year following the date of your request.
5. If you make a request to change your Personal Benefits during an annual enrollment period, your Personal Benefits will become effective on the first day of the calendar year following the annual enrollment period, subject to the Active Work Requirement.

B. Active Work Requirement

You must be Actively at Work in order for your Personal Benefits to become effective. If you are not Actively at Work on the date when your Personal Benefits would otherwise become effective, your Personal Benefits will become effective on the first day after you return to Active Work.

C. Reinstatement of Benefits

If your Personal Benefits end because you do not make a required contribution to their cost, you may make a request to reinstate them, subject to the foregoing provisions.

Form G.23000-D1

EFFECTIVE DATES OF DEPENDENT BENEFITS

A. Making a Request for Benefits

1. In order to become insured for Dependent Benefits under This Plan, you must make a written request to the Employer on the flexible benefits enrollment form furnished by the Employer.

Requests to be insured for Dependent Benefits may only be made:

- a. during the thirty-one day period following your Dependent Benefits Eligibility Date; or
- b. within thirty-one days of a Qualifying Event, provided that the change in coverage is consistent with your new family status.

If you are already insured for Dependent Benefits, requests for changes in your Dependent Benefits may only be made:

- a. during the annual enrollment period, as designated by the Employer and reported to you; or
 - b. within thirty-one days of a Qualifying Event, provided that the change in coverage is consistent with your new family status.
2. If you make a request to be insured for Dependent Benefits within thirty-one days of your Dependent Benefits Eligibility Date, your Dependent Benefits will become effective, on the latest of:
 - a. your Dependent Benefits Eligibility Date; and

No more than the Maximum Allowed Charge for the types of dental services shown in section C will be covered by the Dental Expense Benefits. The Maximum Allowed Charge is the lower of:

- a. the amount charged by the Participating Provider for the service or supply; and
- b. the maximum amount that the Participating Provider agreed with us to charge for that service or supply. This maximum amount is specified or based on the amounts specified in the Preferred Dentist Program Table of Maximum Allowed Charges.

2. For Out-of-Network Benefits

The charges for the types of dental services shown in section C. These services must be:

- a. performed or prescribed by a Dentist who is not a Participating Provider; and
- b. necessary (see NOTICES) as determined by Metropolitan in terms of generally accepted dental standards.

No more than the Reasonable and Customary Charge for the types of dental services shown in section C will be covered by the Dental Expense Benefits. The Reasonable and Customary Charge is the lowest of:

- a. the usual charge by the Dentist or other provider of the services or supplies for the same or similar services or supplies; or
- b. the usual charge of most other Dentists or other providers in the same geographic area for the same or similar services or supplies; or
- c. the actual charge for the services or supplies.

With respect to In-Network Benefits and Out-of-Network Benefits, there may be more than one way to treat a dental problem. If, in our view, an adequate method or material which costs less could have been used, the Dental Expense Benefits will be based on the method or material which costs less. The rest of the cost will not be a Covered Dental Expense. See section E for examples that show how this works.

"Deductible Amount" means the amount shown in the SCHEDULE OF BENEFITS. The Deductible Amount is an annual amount.

The Deductibles during any one Dental Expense Period will not apply to Covered Dental Expenses for your Family after you incur Covered Dental Expenses for Covered Persons in your Family and those expenses equal the Family Deductible Amount.

"Dental Expense Period" means a period which starts on any January 1 and ends on the next December 31.

"Dentist" means a person licensed by law to practice dentistry. A type of dental service which is performed or prescribed by a Doctor will be considered for Dental Expense Benefits as if it were performed or prescribed by a Dentist.

"Covered Percentage" means the percentage or percentages shown in the SCHEDULE OF BENEFITS.

"In-Network Benefits" means the Dental Expense Benefits provided under This Plan for covered dental services that are provided by a Dentist who is a Participating Provider.

"Out-of-Network Benefits" means the Dental Expense Benefits provided under This Plan for covered dental services that are not provided by a Dentist who is a Participating Provider.

"Preferred Dentist Program Table of Maximum Allowed Charges" means our fee agreement with a Participating Provider in which such Participating Provider has agreed to accept a schedule of maximum fees as payment in full for services rendered.

"Preferred Dentist Program" means our program to offer a Covered Person the opportunity to receive dental care from Dentists who are designated by us as Participating Providers. When dental care is given by Participating Providers, the Covered Person will generally incur less out-of-pocket cost for the services rendered.

"Participating Provider" means a Dentist who has been selected by us for inclusion in the Preferred Dentist Program. These Participating Providers agree to accept our Preferred Dentist Program Table of Maximum Allowed Charges as payment in full for services rendered.

"Non-Participating Provider" means a Dentist who is not a Participating Provider.

"Preferred Dentist Program Directory" means the list which consists of selected Dentists who:

1. are located in the Covered Person's area; and
2. have been selected by us to be Participating Providers and part of the Preferred Dentist Program. These Participating Providers agree to accept our Preferred Dentist Program Table of Maximum Allowed Charges as payment in full for services rendered.

The list will be periodically updated.

B. COVERAGE

1. When Benefits May Be Payable

We will pay Dental Expense Benefits if you incur Covered Dental Expenses:

- a. for a Covered Person during a Dental Expense Period; and
- b. while you are covered for the Dental Expense Benefits for that Covered Person; and
- c. the In-Network Covered Dental Expenses are more than the In-Network Deductible Amount.

We will also pay Dental Expense Benefits if you incur Out-of-Network Covered Dental Expenses:

- a. for a Covered Person during a Dental Expense Period; and
- b. while you are covered for the Dental Expense Benefits for that Covered Person; and
- c. the sum of the In-Network Covered Dental Expenses and Out-of-Network Covered Dental Expenses are more than the Out-of-Network Deductible Amount.

An expense is "incurred" on the date the type of dental service for which the charge is made is prepared.

2. How Benefits Are Determined

Benefits will be equal to the Covered Percentage of those Covered Dental Expenses which are more than the Deductible Amount. However:

- a. The sum of all benefits for all Covered Dental Expenses incurred for a Covered Person during any one Dental Expense Period will not be more than the Maximum Benefit For One Dental Expense Period shown in the SCHEDULE OF BENEFITS.
- b. **Orthodontic Covered Services** - Orthodontic treatment generally consists of initial placement of an appliance and a specified number of periodic follow-up visits as initially requested by the Dentist. Orthodontic treatment also includes other services required for the orthodontic treatment such as transseptal fibrotomy and extractions of certain teeth.

Upon the initial placement of the appliance, which may include other services such as the initial workup, we will pay an amount not to exceed 20% of the Aggregate Maximum Benefit for Orthodontic Treatment.

After the initial placement of the orthodontic appliance we will pay any remaining benefit during the course of the orthodontic treatment (including periodic follow-up visits) as follows:

- i. The amount payable during the scheduled course of the orthodontic treatment will be the lower of:
 - (a) the amount of the Covered Dental Expense times the Covered Percentage for Orthodontia; and
 - (b) the remaining amount of the Aggregate Maximum Benefit for Orthodontic Treatment (For All Dental Expense Periods).
- ii. We will divide the benefit payable for the course of the orthodontic treatment by the number of months in the scheduled course of the orthodontic treatment (but no more than 24 months). We will use 3 times the resulting amount as the most we will pay for each 3-month period during the scheduled course of the orthodontic treatment.

Benefits will only be payable during the scheduled course of the orthodontic treatment if:

- i. Dental Expense Benefits are in effect for the person receiving the orthodontic treatment; and
- ii. proof is given to Us that the orthodontic treatment is continuing.

For minor orthodontia services that are performed in one visit and do not require follow-up visits, we will pay the amount of the Covered Dental Expense times the Covered Percentage for Orthodontia.

The sum of all benefits for all Covered Dental Expenses incurred for a Covered Person for orthodontic treatment, will not be more than the applicable Aggregate Maximum Benefit for Orthodontic Treatment as shown in the SCHEDULE OF BENEFITS. This includes any services required for orthodontia received prior or related to the initial placement of an orthodontia appliance.

Benefits For Orthodontic Services Begun Prior To This Dental Expense Benefits - If the initial placement of the appliance was made prior to these Dental Expense Benefits being in effect, no benefits will be payable under these Dental Expense Benefits for the initial placement of the appliance.

If periodic follow-up visits commenced prior to these Dental Expense Benefits being in effect:

- i. the number of months for which benefits are payable based on the scheduled course of orthodontic treatment will be reduced by the number of months of treatment performed before these Dental Expense Benefits were in effect; and
- ii. the total amount of the benefit payable that we would have normally provided for treatment which was started while these Dental Expense Benefits were in effect will be reduced proportionately.

In order to determine what are the amounts of Covered Dental Expenses, we may ask for X-rays and other diagnostic and evaluative materials. If they are not given to us, we will determine Covered Dental Expenses on the basis of the information which is available to us. This may reduce the amount of benefits which otherwise would have been payable.

3. How the Preferred Dentist Program Works

Free Choice Of A Dentist:

A Covered Person is always free to choose the services of a Dentist who is either:

- a. a Participating Provider; or
- b. a Non-Participating Provider.

Benefits under This Plan will be determined and paid in either case, except that the Covered Person will generally incur less out-of-pocket cost if a Participating Provider is chosen.

C. DENTAL SERVICES WHICH MAY BE COVERED DENTAL EXPENSES

1. Type A Expenses

- a. Oral exams but not more than twice in a Dental Expense Period.
- b. Preventive treatment:
 - i. scaling and polishing of teeth (oral prophylaxis) but not more than twice in a Dental Expense Period; and
 - ii. topical fluoride treatment but not more than twice in a Dental Expense Period.
- c. Space maintainers for a Dependent child under 19 years of age.
- d. Sealant material for each non-restored molar tooth of a Dependent child under age 14.
- e. Emergency Palliative Treatment.
- f. Periodontal Cleaning where periodontal treatment (such as osseous surgery, gingivectomy, gingivoplasty, or gingival curettage) has been previously performed, but not more than twice in a Dental Expense Period.

2. Type B Expenses

- a. Amalgam or resin fillings.
- b. X-rays:
 - i. full mouth X-rays but not more than once every 36 months; and
 - ii. bitewing X-rays but not more than twice in a Dental Expense Period.
- c. Extractions.
- d. Root canal treatment.
- e. Periodontal scaling and root planing.
- f. Treatment of periodontal disease and other diseases of the gums and tissues of the mouth.
- g. Oral surgery.
- h. Administration of general anesthesia, when dentally necessary (see NOTICES) as determined by Metropolitan in terms of generally accepted dental standards in connection with oral surgery, extractions, or other covered dental services.
- i. Injections of antibiotic drugs.
- j. Relinings and rebasings of existing removable dentures but not more than once in 36 months.
- k. Repair or re-cementing of:
 - i. crowns; or
 - ii. inlays or onlays; or
 - iii. dentures; or
 - iv. bridgework.
- l. Occlusional guards.
- m. Consultations.

3. Type C Expenses

- a. Those services needed to replace one or more natural teeth which are lost while Dental Expense Benefits for the Covered Person are in effect for:
 - i. Installation of fixed bridgework done for the first time.
 - ii. Installation for the first time of:
 - 1. a partial removable denture; or

D. EXCLUSIONS - DENTAL SERVICES WHICH ARE NOT COVERED DENTAL EXPENSES

1. Services or supplies received by a Covered Person before the Dental Expense Benefits start for that person.
2. Services not performed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
 - a. scaling and polishing of teeth; or
 - b. fluoride treatments.
3. Cosmetic surgery or supplies. However, any such surgery or supply will be covered if:
 - a. it otherwise is a Covered Dental Expense; and
 - b. it is required for reconstructive surgery which is incidental to or follows surgery which results from a trauma, an infection or other disease of the involved part; or
 - c. it is required for reconstructive surgery because of a congenital disease or anomaly of a Dependent child which has resulted in a functional defect.
4. Replacement of a lost, missing or stolen crown, bridge or denture.
5. Services or supplies which are covered by any workers' compensation laws or occupational disease laws.
6. Services or supplies which are covered by any employers' liability laws.
7. Services or supplies which any employer is required by law to furnish in whole or in part.
8. Services or supplies received through a medical department or similar facility which is maintained by the Covered Person's employer.
9. Repair or replacement of an orthodontic appliance.
10. Services or supplies received by a Covered Person for which no charge would have been made in the absence of Dental Expense Benefits for that Covered Person.
11. Services or supplies for which a Covered Person is not required to pay.
12. Services or supplies which are deemed experimental in terms of generally accepted dental standards.
13. Services or supplies received as a result of dental disease, defect or injury due to an act of war, or a warlike act in time of peace, which occurs while the Dental Expense Benefits for the Covered Person are in effect.
14. Adjustment of a denture or a bridgework which is made within 6 months after installation by the same Dentist who installed it.
15. Any duplicate appliance or prosthetic device.
16. Use of material or home health aids to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluoride and sealant material.

17. Instruction for oral care such as hygiene or diet.
18. Periodontal splinting.
19. Myofunctional therapy or correction of harmful habits.
20. Implantology.
21. Services or supplies to the extent that benefits are otherwise provided under This Plan or under any other plan which the Employer (or an affiliate) contributes to or sponsors.
22. Initial installation of a denture or bridgework to replace one or more natural teeth lost before the Dental Expense Benefits started for the Covered Person.
23. Charges for broken appointments.
24. Charges by the Dentist for completing dental forms.
25. Sterilization supplies.
26. Services or supplies furnished by a family member.
27. Treatment of temporomandibular joint disorders.

E. EXAMPLES OF ALTERNATE BENEFITS

Dental Expense Benefits will be based on the materials and method of treatment which cost the least and which, in our view, meet generally accepted dental standards.

1. Amalgam and Composite Fillings

When an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, we will base our benefit determination upon the amalgam filling which is the less costly service.

2. Inlays, Onlays, Crowns and Gold Foil

If a tooth can be repaired to our satisfaction according to generally accepted dental standards by a less costly method than an inlay, onlay, crown or gold foil, Dental Expense Benefits will be based on the adequate method of repair which costs the least.

3. Crowns, Pontics, and Abutments

Veneer materials may be used for front teeth or bicuspid. However, Dental Expense Benefits will be based on the adequate veneer materials which cost the least.

4. Bridgework and Dentures

Dental Expense Benefits will be based on the adequate method of treating the dental arch which costs the least. In some cases removable dentures may serve as well as fixed bridgework. If dentures are replaced by fixed bridgework, the Dental Expense Benefits will be based on the cost of a replacement denture unless adequate results can only be achieved with fixed bridgework.

These are not the only examples of alternate benefits. To find out how much your Dental Expense Benefits will be, see section F.

F. PRE-DETERMINATION OF BENEFITS

If a dental bill is expected to be \$300 or more, before the Dentist starts the treatment, a Covered Person can find out what Dental Expense Benefits will be paid under This Plan. To do this, the Covered Person should send a claim form to us in which the Dentist tells us:

1. the work to be done; and
2. what the cost will be.

We will then tell the Covered Person what Dental Expense Benefits This Plan may pay. If the Covered Person does not use this method to find out what Dental Expense Benefits This Plan may pay, our decision will be final and binding with regard to what are Covered Dental Expenses and what Dental Expense Benefits This Plan may pay.

This method should not be used for:

1. emergency treatment; or
2. routine oral exams; or
3. X-rays, scaling and polishing, and fluoride treatments; or
4. dental services which cost less than \$300.

G. IMPACT OF GOVERNMENT PLANS ON DENTAL EXPENSE BENEFITS

To the extent that services or supplies, or benefits for them, are available to a Covered Person under a Government Plan, as defined below, they will not be considered for Dental Expense Benefits under This Plan. This provision will apply whether or not the Covered Person is enrolled for all Government Plans for which that Covered Person is eligible.

This provision will not apply to a Government Plan if that Government Plan requires that Dental Expense Benefits under This Plan be paid first.

A "Government Plan" is any plan, program or coverage, other than Medicare:

1. which is established under the laws or the regulations of any government; or
2. in which any government participates other than as an employer.

H. DENTAL EXPENSE COVERAGE AFTER BENEFITS END

No benefits will be payable for Covered Dental Expenses incurred by a Covered Person after the Dental Expense Benefits for that person end. This will apply even if we have pre-determined benefits for dental services. However, benefits for Covered Dental Expenses incurred for a Covered Person for the following services will be paid after Dental Expense Benefits end:

1. For a prosthetic device if:
 - a. the Dentist prepared the abutment teeth and made impressions while Dental Expense Benefits for the Covered Person were in effect; and
 - b. the device is installed within 90 days after the date the Dental Expense Benefits end; or

2. For a crown if:
 - a. the Dentist prepared the tooth for the crown while the Dental Expense Benefits for the Covered Person were in effect; and
 - b. the crown is installed within 90 days after the date the Dental Expense Benefits end; or
3. For root canal therapy if:
 - a. the Dentist opened into the pulp chamber while the Dental Expense Benefits for the Covered Person were in effect; and
 - b. the treatment is finished within 90 days after the date the Dental Expense Benefits end.

I. PAYMENT OF BENEFITS

Dental Expense Benefits will be paid to:

1. the Dentist, if you have assigned benefits directly to the Dentist; or
2. you, in all other cases.

We will pay benefits when we receive satisfactory written proof of your claim. Proof must be given to us not later than 90 days after the end of the Dental Expense Period in which the Covered Dental Expenses were incurred. If proof is not given on time, the delay will not cause a claim to be denied or reduced as long as proof is given as soon as possible.

Form G.23000-13E

WHEN BENEFITS END

- A. All of your benefits will end on the last day of the calendar month in which your employment ends. Your employment ends when you cease Active Work as an Employee. However, for the purpose of benefits, the Employer may deem your employment to continue for certain absences. See CONDITIONS UNDER WHICH YOUR ACTIVE WORK IS DEEMED TO CONTINUE.
- B. If This Plan ends in whole or in part, your benefits which are affected will end.
- C. Your Dependent Benefits will end on the earlier of:
 1. the date that the Dependent ceases to be your Dependent; or
 2. the date of your death.
- D. If a Covered Person does not make a payment which is required by the Employer to the cost of any benefits, those benefits will end; they will end on the last day of the period for which a payment required by the Employer was made.

The end of any type of benefits on account of a Covered Person will not affect a claim which is incurred before those benefits ended.

The Dental Expense Benefits for a Covered Person may be continued in accordance with the Federal law called COBRA. See the pages entitled NOTICE OF YOUR RIGHT AND YOUR DEPENDENTS' RIGHT TO CONTINUE DENTAL BENEFITS.

Form G.23000-F

CONDITIONS UNDER WHICH YOUR ACTIVE WORK IS DEEMED TO CONTINUE

If you are not Actively at Work as an Employee because of a situation set forth below, the Employer may deem you to be in Active Work as an Employee only for the purpose of continuing your employment and only for the periods specified below in order that certain of your benefits under This Plan may be continued.

All such benefits will be subject to prior cessation as set forth in WHEN BENEFITS END.

In any case, the benefits will end on:

1. the date the Employer notifies us that your benefits are not to be continued; or
2. the end of the last period for which the Employer has paid premiums to us for your benefits.

Your Sickness or Injury, Your Leave of Absence, Your Lay Off

With respect to all Personal Benefits and all Dependent Benefits, the period determined in accordance with the Employer's general practice for an Employee in your job class.

However, in the event the leave qualifies under the Family and Medical Leave Act of 1993 (FMLA) or a similar state law, the period cannot be longer than the leave required by the law. If a leave qualifies under more than one such law, the period cannot be longer than the longest leave permitted under any of the laws.

Form G.23000-L

COORDINATION OF BENEFITS

A. Definitions

"Plan" means a plan which provides benefits or services for, or by reason of, dental care and which is:

1. a group insurance plan; or
2. a group blanket plan, but not including school accident-type coverages covering students in:
 - a. a grammar school;
 - b. a high school; or

c. a college;

for accident only (including athletic injuries) either on a 24 hour basis or on a "to and from school basis"; or

3. a group practice plan; or
4. a group service plan; or
5. a group prepayment plan; or
6. any other plan which covers people as a group; or
7. a governmental program or coverage required or provided by any law, except Medicaid, but including any motor vehicle No Fault coverage which is required by law.

Each policy, contract or other arrangement for benefits or services will be treated as a separate Plan. Each part of such a Plan which reserves the right to take the benefits or services of other Plans into account to determine its benefits will be treated separately from those parts which do not.

"This Plan" means only those parts of This Plan which provide benefits or services for dental care. The provisions of This Plan which limit benefits based on benefits or services provided under:

1. Government Plans; or
2. Plans which the Employer (or an affiliate) contributes to or sponsors;

will not be affected by these Coordination of Benefits provisions.

"Primary Plan/Secondary Plan" When This Plan is a Primary Plan, it means that This Plan's benefits are determined:

1. before those of the other Plan; and
2. without considering the other Plan's benefits.

When This Plan is a Secondary Plan, it means that This Plan's benefits:

1. are determined after those of the other Plan; and
2. may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more of those other Plans and may be a Secondary Plan as to a different Plan or Plans.

"Allowable Expense" means any reasonable and customary charge which meets all of the following tests:

1. it is a charge for an item of necessary dental expense; and
2. it is an expense which a Covered Person must pay; and
3. it is an expense at least a part of which is covered under at least one of the Plans which covers the person for whom claim is made.

When a Plan provides fixed benefits for specified events or conditions rather than benefits based on expenses, any benefits under that Plan will be deemed to be Allowable Expenses.

When a Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

However, Allowable Expenses do not include:

- a. expenses for services rendered because of:
 1. an Occupational Sickness; or
 2. an Occupational Injury.
- b. any amount of benefits reduced under a Primary Plan because the Covered Person does not comply with the Plan provisions. Examples of such provisions are those related to:
 1. second surgical opinions;
 2. precertification of admissions or services; and
 3. preferred provider arrangements.

Only benefit reductions based upon provisions similar in purpose to those described in the prior sentence and which are contained in the Primary Plan may be excluded from Allowable Expenses. This provision will not be used by a Secondary Plan to refuse to pay benefits because a Health Maintenance Organization member has elected to have health care services provided by a non-HMO provider and the HMO, pursuant to its contract, is not obliged to pay for providing those services.

"Claim Determination Period" means a period which starts on any January 1 and ends on the next December 31. However, a Claim Determination Period for any Covered Person will not include periods of time during which that person is not covered under This Plan.

"Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

B. Effect on Benefits

1. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:
 - a. the other Plan has rules coordinating its benefits with those of This Plan; and
 - b. both those rules and This Plan's rules in subsection 3 of this Section B require that This Plan's benefits be determined before those of the other Plan.
2. If This Plan is a Secondary Plan, when the total Allowable Expenses incurred for a Covered Person in any Claim Determination Period are less than the sum of:
 - a. the benefits that would be payable under This Plan without applying this Coordination of Benefits provision; and
 - b. the benefits that would be payable under all other Plans without applying Coordination of Benefits or similar provisions;

the benefits described in item 2(a) of this section B will be reduced. The sum of these reduced benefits plus all benefits payable for such Allowable Expenses under all other Plans will not exceed the total of the Allowable Expenses. Benefits payable under all other Plans include all benefits that would be payable if the proper claims had been given on time.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against the benefit limits of This Plan.

3. Rules for Determining the Order in which Plans Determine Benefits. When more than one Plan covers the person for whom Allowable Expenses were incurred, the order of benefit determination is:

a. Non-dependent/Dependent. The Plan which covers that person other than as a dependent (for example, as an employee, member, subscriber or retiree) determines its benefits before the Plan which covers that person as a dependent; except that if the person is also a Medicare beneficiary, and as a result of the rules established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

- i. Secondary to the Plan covering the person as a dependent; and
- ii. Primary to the Plan covering the person as other than a dependent (e.g., a retired person);

then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering that person as other than a dependent.

b. Child Covered under More than One Plan. When This Plan and another Plan cover the same child as a dependent of different persons, called "parents":

- i. the Primary Plan is the Plan of the parent whose birthday is earlier in the year if:
 1. the parents are married;
 2. the parents are not separated (whether or not they ever have been married); or
 3. a court decree awards joint custody without specifying that one party is responsible for providing health care coverage.

For example, if one parent's birthday were January 8 and the other parent's birthday were March 3, then the Plan covering the parent with the January 8 birthday would determine its benefits before the Plan covering the parent with the March 3 birthday.

- ii. if both parents have the same date of birth (excluding year of birth), the Plan which covered the parent for the longer time determines its benefits before the Plan which covered the other parent for the shorter time.
- iii. if the specific terms of a court decree state that one of the parents is responsible for the child's healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This paragraph does not apply with respect to any Claim Determination Period during which any benefits are actually paid or provided before that Plan has that actual knowledge of the terms of the court decree.
- iv. if the parents are not married or are separated (whether or not they have ever been married) or are divorced, the order of benefits is:
 1. the Plan of the Custodial Parent;

2. the Plan of the spouse of the Custodial Parent;
 3. the Plan of the Non-Custodial Parent;
 4. the Plan of the spouse of the Non-Custodial Parent.
- c. Active/Laid-off or Retired Employee. The Plan which covers that person as an active employee (or as that employee's dependent) is Primary to a Plan which covers that person as a laid-off or retired employee (or as that employee's dependent). If the Plan which covers that person has not adopted this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule shall not apply.
- d. Continuation Coverage. The Plan which covers the person as an active employee, member or subscriber (or as that employee's dependent) is Primary to a Plan which covers that person under a right of continuation pursuant to federal law (e.g., COBRA) or state law. If the Plan which covers that person has not adopted this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule d. shall not apply.
- e. Longer/Shorter Time Covered. If none of the above rules determines the order of benefits, the Plan which has covered the Employee for the longer time determines its benefits before the Plan which covered that person for the shorter time.

C. Right to Receive and Release Needed Information

Certain facts are needed to apply these Coordination of Benefits rules. We have the right to decide which facts we need. We may get facts from or give them to any other organization or person. We need not tell, nor get the consent of, any person or organization to do this. To obtain all benefits available, a claim should be filed under each Plan which covers the person for whom Allowable Expenses were incurred. Each person claiming benefits under This Plan must give us any facts we need to pay the claim.

D. Facility of Payment

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, we may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

E. Right of Recovery

If the amount of the payments made by us is more than we should have paid under this Coordination of Benefits provision, we may recover the excess from one or more of:

1. the persons we have paid or for whom we have paid;
2. insurance companies; or
3. other organizations.

The "amount of the payment made" includes the reasonable cash value of any benefits provided in the form of services.

NOTICES

This certificate is of value to you. It should be kept in a safe place.

As soon as your benefits end, you should consult your Employer to find out what rights, if any, you may have to continue your protection.

If you or your Dependents had coverage under a prior plan of benefits, please consult your Employer to determine if there are any additional provisions which affect your benefits under This Plan.

The fact that a Dentist may recommend that a Covered Person receive a dental service does not mean:

1. that the dental service will be deemed to be necessary; or
2. that benefits under This Plan will be paid for the expenses of the dental service.

Metropolitan will make the decision as to whether the dental service:

1. is necessary in terms of generally accepted dental standards; and
2. is qualified for benefits under This Plan.

PROCEDURES FOR CLAIM REVIEW

INTERNAL PROCEDURES FOR CLAIM REVIEW BY METLIFE

First Level of Review

MetLife maintains a procedure by which a denied claim may be appealed. In the event a claim is denied, you can request a review of your claim. This request for review should be sent in writing to Group Claims Review, at the address of the MetLife office which processed the claim. This request should be sent to us within 60 days after you receive notice of denial of the claim.

When requesting a review, please state the reason you believe the claim was improperly denied. You and your Dentist should submit any information that is appropriate such as diagnostic materials, x-rays, or narrative. Decisions on your appeal will be made no later than 60 days after receipt of the request for review.

Second Level of Review

If the appeal is not resolved to your satisfaction, you can appeal the action to second level of review for reconsideration. This second level of review is done through senior level consultants who make the final recommendations. Decisions on your appeal in the second level of review will be made no later than 60 days after receipt of the request for reconsideration.

Please note, by undertaking a second level review you may foreclose your right to an external appeal as an external appeal must be filed within 45 days of the Final Adverse Determination of the first level review.

EXTERNAL PROCEDURES FOR CLAIM REVIEW OUTSIDE OF METLIFE

New York state law gives you the right to an external appeal when payment of benefits for dental services have been denied on the basis that the services are not dentally necessary or that the services are experimental or investigational.

If you have received a Final Adverse Determination after our first level of review, you can request an external appeal by completing an [application form](#) and sending it to the New York State Insurance Department within 45 days:

- of when you received the Final Adverse Determination; or
- of receiving written confirmation from us that the internal appeal process has been waived.

Final Adverse Determination means a written notification from us that your claim for dental benefits has been denied through our appeal process.

You may obtain an application form or any additional information by calling us at 1-800-638-5433 or by calling the New York Insurance Department at 1-800-400-8882. You may also obtain an application or further information by visiting the New York Insurance Department's web site at www.ins.state.ny.us.

Eligibility for an External Appeal

To be eligible for an external appeal, payment of benefits for dental services must have been denied on the basis that the services are not dentally necessary or that the services are experimental or investigational and:

- you must have received a Final Adverse Determination as a result of our internal utilization review appeal process; or
- you and MetLife must have agreed to waive that appeal process.

If you do not file a request for an external appeal with the state within this 45 day period, you will not be eligible for an external appeal. MetLife has two levels of internal appeals, you must file a request for external appeal within 45 days of your receipt of the Final Adverse Determination from our first level appeal process to be eligible for an external appeal.

If services are denied as experimental or investigational, you must have a life-threatening or disabling condition or disease to be eligible for an external appeal and your Dentist must complete the Attending Physician Attestation form and send the form to the New York Insurance Department. The Attending Physician Attestation form is included as part of the application form.

You may only appeal a service or procedure that is a Covered Service under this certificate. The external appeal process may not be used to expand your dental coverage.

Eligibility for an Expedited External Appeal

If your attending Dentist attests that a delay in providing the treatment or service poses an imminent or serious threat to your health you may request an expedited appeal. When requesting an expedited appeal, make sure you give the Attending Physician Attestation form to your Dentist to complete. Your appeal will not be forwarded to the external appeal agent until your Dentist sends this attestation to the Insurance Department.

Time Periods for External Appeals

For standard appeals, the external appeal agent must make a determination within 30 days of receiving your request for an external review from the state. If additional information is requested, the external appeal agent has five additional business days to make a determination.

For expedited appeals, the external appeal agent must make a determination within three days of receiving your request for an external review from the state.

The Cost to You for an External Appeal

We may charge you a fee of up to \$50.00 for an external appeal. If We determine that the fee will pose a hardship, you will not be required to pay a fee.

If the external appeal agent overturns the Final Adverse Determination, the fee will be refunded to you.

Submission of Information

If your case is determined to be eligible for external review, you will be notified of the certified external appeal agent assigned to review your case.

MetLife will send your dental and treatment records to the external appeal agent.

When the external appeal agent reviews your case, the agent may request additional information from you or your Dentist. This information should be sent immediately to the external appeal agent.

You and your Dentist can submit information even when the external appeal agent has not requested specific information. You must submit this information to the New York State Insurance Department within 45 days:

- of when you received the Final Adverse Determination; or
- of receiving written confirmation from us that the internal appeal process has been waived.

Once the external appeal agent makes a determination or your 45 day time period ends, you will not be able to submit additional information.

The external appeal application contains a release of medical records provision that you must sign to authorize the release of medical and treatment records, including HIV, mental health and alcohol and drug abuse records to the certified external appeal agent assigned to review your appeal.

Notification of a Decision

When the external appeal agent has made the decision:

- for standard appeals, you and MetLife will be notified in writing within two business days; or
- for expedited appeals, you and MetLife will be notified immediately by telephone or fax. Written notification will follow.

The decision of the external appeal agent is binding on you and MetLife.

Our Home Office is located at One Madison Avenue, New York, New York 10010.

Form G.23000-E

THIS IS THE END OF THE CERTIFICATE. THE FOLLOWING IS ADDITIONAL INFORMATION.

NOTICE OF YOUR RIGHT AND YOUR DEPENDENTS' RIGHT TO CONTINUE DENTAL BENEFITS

When your employment terminates for any reason other than your gross misconduct, or if your hours worked are reduced so that your coverage terminates, you and your covered dependents may continue coverage under This Plan for a period of up to 18 months. However, if it is determined under the terms of the Social Security Act that you or your covered dependent is disabled within 60 days after your termination of employment or reduction of hours, you and your covered dependents may continue your dental coverage under This Plan for an additional 11 months after the expiration of the 18 month period. During the additional 11 months of coverage, your cost for that coverage will be approximately 50% higher than it was during the preceding 18 months. In addition, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may continue coverage under This Plan for up to 36 months. Also, your covered children may continue coverage under This Plan for up to 36 months after they no longer qualify as covered dependents under the terms of This Plan.

During the continuation period, a child of yours that is (1) born; (2) adopted by you; or (3) placed with you for adoption, will be treated as if the child were a covered dependent at the time coverage was lost due to an event described above.

This continuation will terminate on the earliest of:

1. the end of the 18, 29 or 36 month continuation period, as the case may be;
2. the date of expiration of the last period for which the required payment was made;
3. the date, after a Covered Person elects to continue coverage, that the Covered Person first becomes covered under another group health plan as long as the new plan does not contain any exclusion or limitation with respect to any preexisting condition on the Covered Person;
4. the date This Plan is cancelled.

Notice will be given when you or your covered dependents become entitled to continue coverage under the Plan. You, or they, will then have at least 60 days to elect to continue coverage. However, you or your covered spouse or your covered child must notify the Employer within 60 days in the event you receive a determination of disability under the terms of the Social Security Act, you become divorced or legally separated, or when your dependent child no longer qualifies as a covered dependent under This Plan.

Any person who elects to continue coverage under the Plan must pay the full cost of that coverage (including both the share you now pay and the share your Employer now pays), plus any additional amounts permitted by law. Your payments for continued coverage must be made on the first day of each month in advance.

ERISA INFORMATION

NAME OF THE PLAN

Dental Assistance Plan for Rensselaer Polytechnic Institute Employees, ("Plan").

NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR

Rensselaer Polytechnic Institute
2144 Burdett Avenue
Troy, NY 12180
518-276-4094

EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER

14-1340095 506

TYPE OF PLAN

Employee Welfare Plan including:

Dental Expense Benefits

TYPE OF ADMINISTRATION

The above listed benefits are insured by Metropolitan Life Insurance Company, ("MetLife").

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made upon the Plan Administrator at the above address. For disputes arising under those portions of the Plan insured by MetLife, service of legal process may be made upon MetLife at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

ELIGIBILITY FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS

Your MetLife certificate describes the eligibility requirements for insurance under the Plan. It also includes a detailed description of insurance provided by MetLife under the Plan.

PLAN TERMINATION OR CHANGES

The group policy sets forth those situations in which the Employer and/or MetLife have the right to end the policy.

The Employer reserves the right to change or terminate the Plan at any time. Therefore, there is no guarantee that you will be eligible for the benefits described herein for the duration of your employment. Any such action will be taken only after careful consideration.

Your consent or the consent of your beneficiary is not required to terminate, modify, amend, or change the Plan.

In the event your coverage ends in accord with the "When Benefits End" provision of your certificate, you may still be eligible to receive benefits. The circumstances under which benefits are available are described in your MetLife certificate.

CONTRIBUTIONS

You must make a contribution to the cost of Personal Dental Expense and Dependent Dental Expense Benefits.

The total premium rate for insurance provided under the Plan by MetLife is set by MetLife.

PLAN YEAR

The Plan's fiscal records are kept on a Plan year basis beginning each January 1 and ending on the following December 31.

QUALIFIED DOMESTIC RELATIONS ORDERS / QUALIFIED MEDICAL CHILD SUPPORT ORDERS

You and your beneficiaries can obtain, without charge, from the Plan Administrator a copy of any procedures governing Qualified Domestic Relations Orders (QDRO) and Qualified Medical Child Support Orders (QMCSO).

CLAIMS INFORMATION

Dental Expense Benefits Claims

Procedures for Presenting Claims for Dental Expense Benefits

All claim forms needed to file for benefits under the group insurance program can be obtained from the Employer who can also answer questions about the insurance benefits and to assist you or, if applicable, your beneficiary in filing claims. Dental claim forms can also be downloaded from www.metlife.com/dental.

Routine Questions

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-800-942-0854.

Claim Submission

For claims for dental expense benefits, the claimant must complete the appropriate claim form and submit the required proof and mail to the address indicated on the claim form. MetLife will also accept electronic, telephonic and Internet claims submitted on your behalf by your Dentist.

Claim forms must be submitted in accordance with the instructions on the claim form.

Initial Determination

After you submit a claim for dental expense benefits to MetLife, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a 30 day period from the date you submitted your claim; except for situations requiring an extension of time of up to 15 days because of matters beyond the control of the Plan. If MetLife needs such an extension, MetLife will notify you prior to the expiration of the initial 30 day period, state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge.

Appealing the Initial Determination

If MetLife denies your claim, you may make two appeals of the initial determination. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the Explanation of Benefits within 180 days of receiving MetLife's decision.

Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- Whether the appeal is the first or second appeal of the initial determination
- An explanation why you are appealing the initial determination

As part of each appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination or determination on the first appeal, MetLife will conduct a full and fair review of your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within 30 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 30 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 30 day period, state the reason(s) why such an extension is needed, and state when it will make its determination.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

When the claim has been processed, you will be notified of the benefits paid. If any benefits have been denied, you will receive a written explanation.

Urgent Care Claim Submission

A small number of claims for dental expense benefits may be urgent care claims. Urgent care claims for dental expense benefits are claims for reimbursement of dental expenses for services which a dentist familiar with the dental condition determines would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Of course any such claim may always be submitted in accordance with the normal claim procedures. However your dentist may also submit such a claim to MetLife by telephoning MetLife and informing MetLife that the claim is an Urgent Care Claim. Urgent Care Claims are processed according to the procedures set out above, however once a claim for urgent care is submitted, MetLife will notify you of the determination on the claim as soon as possible, but no later than 72 hours after the claim was filed. If you or your covered dependent does not provide the claims administrator with enough information to decide the claim, MetLife will notify you within 24 hours after it receives the claim of the further information that is needed. You will have 48 hours to provide the information. If the needed information is provided, MetLife will then notify you of the claim decision within 48 hours after MetLife received the information. If the needed information is not provided, MetLife will notify you or your covered dependent of its decision within 120 hours after the claim was received.

If your urgent care claim is denied but you receive the care, you may appeal the denial using the normal claim procedures. If your urgent care claim is denied and you do not receive the care, you can request an expedited appeal of your claim denial by phone or in writing. MetLife will provide you any necessary information to assist you in your appeal. MetLife will then notify you of its decision within 72 hours of your request in writing. However, MetLife may notify you by phone within the time frames above and then mail you a written notice.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Dental Plan Insurance

Continue dental insurance for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Privacy of Your Medical Information

This Plan operates in accordance with regulations under the Health Insurance Portability and Accountability Act as set forth in 45 CFR Parts 160 and 164, and as they may be amended ("HIPAA"), with respect to protected health information ("PHI") as that term is defined in HIPAA. For purposes of the Plan, PHI generally consists of individually identifiable information about you or your dependents, including health and demographic information, that relates to your or their eligibility for dental benefits under the Plan.

Permitted Uses and Disclosures of PHI by the Plan and the Plan Sponsor

The Plan and the Plan Sponsor are permitted to use and disclose PHI for the following purposes, to the extent they are not inconsistent with HIPAA:

- For general plan administration, including policyholder service functions, enrollment and eligibility functions, reporting functions, auditing functions, financial and billing functions, to assist in the administration of a consumer dispute or inquiry, and any other authorized insurance or benefit function.
- As required for computer programming, consulting or other work done in respect to the computer programs or systems utilized by the Plan.
- Other uses relating to plan administration which are approved in writing by the Plan Administrator or Privacy Officer.
- At the request of an individual, to assist in resolving claims the individual may have with respect to benefits under the Plan.

Uses and Disclosures of PHI by the Plan and the Plan Sponsor for Required Purposes

The Plan and Plan Sponsor may use or disclose PHI for the following required purposes:

- Judicial and administrative proceedings, in response to lawfully executed process, such as a court order or subpoena.
- For public health and health oversight activities, and other governmental activities accompanied by lawfully executed process.
- As otherwise may be required by law.

Sharing of PHI With the Plan Sponsor

As a condition of the Plan Sponsor receiving PHI from the Plan, the Plan Documents have been amended to incorporate the following provisions, under which the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the plan documents in sections titled "Permitted Uses and Disclosures of PHI by the Plan and the Plan Sponsor" and "Uses and Disclosures of PHI by the Plan and the Plan Sponsor for Required Purposes" above;
- Ensure that any agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor;
- Not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

- Report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures of which it becomes aware;
- Make PHI available to Plan participants for the purposes of the rights of access and inspection, amendment, and accounting of disclosures as required by HIPAA;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;
- If feasible, return or destroy all PHI received from the Plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
- Ensure that adequate separation between the Plan and Plan Sponsor is established in accordance with the following requirements:
 - a. Employees to be Given Access to PHI: The following employees (or class of employees) of the Plan Sponsor are the only individuals that may access PHI provided by the Plan:

HR Representative, Benefits Manager, VP for Human Resources, AVP for Human Resources, Director of Human Resources
 - b. Restriction to Plan Administration Functions: The access to and use of PHI by the employees of the Plan Sponsor designated above will be limited to plan administration functions that the Plan Sponsor performs for the Plan.
 - c. Mechanism for Resolving issues of Noncompliance: If the Plan Administrator or Privacy Officer determines that an employee of the Plan Sponsor designated above has acted in noncompliance with the plan document provisions outlined above, then the Plan Administrator or Privacy Officer shall take or seek to have taken appropriate disciplinary action with respect to that employee, up to and including termination of employment as appropriate. The Plan Administrator or Privacy Officer shall also document the facts of the violation, actions that have been taken to discipline the offending party and the steps taken to prevent future violations.
- Certify to the Plan, prior to the Plan permitting disclosure of PHI to the Plan Sponsor, that the Plan Documents have been amended to incorporate the provisions in this section titled "Sharing of PHI With the Plan Sponsor".

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FUTURE OF THE PLAN

It is hoped that the Plan will be continued indefinitely, but Rensselaer Polytechnic Institute reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

The Board of Directors of Rensselaer Polytechnic Institute shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.

DISCLOSURE STATEMENT - (NEW YORK)

METROPOLITAN LIFE INSURANCE COMPANY

Required Disclosure Statement

The insurance evidenced by this certificate provides dental insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department.